Exhibit 1 to de Reeder Declaration

PERDS : NICS Reporting Form

New York State Dept. of Health

Activity :	NICS Reporting Activity
Organization :	Eastern Long Island Hospital (0891)
Form :	NICS Reporting Form
Data Entity Type :	NICS Patient
Name :	Case Number:127476|Admissions Date NICS:05/23/2014
Time Period :	

Name :	Eastern Long Island Hospital (0891)
Address 1 :	201 MANOR PLACE
Address 2 :	
City :	GREENPORT
State & Zip :	NY-11944
County :	Suffolk (103)
Region :	Metropolitan Area Regional Office
Phone & Fax:	631-477-1000 & 631-477-1746

Note:

As of September 03, 2013, new questions have been added to this form. The additional data fields are needed in NICS record reports to better carry out the objectives of both the NICS and SAFE Act programs.

Transaction Type

Select Transaction Type*

Patient Information

Last Name*

First Name*

Middle Name

Cadence

Sex*

Race*

Date of Birth*

Is a valid SSN available for the patient?*

If you answered "No" to the above you must check this box, asserting that a valid SSN is unattainable by any means.

If you answered "Yes" to the above, enter a valid Social Security Number (no dashes or spaces). DO NOT enter a fake or dummy SSN.

Enter as much information that you are able to provide for the patient's address:

Address 1

Address 2

City

State

Zip

Is information unavailable for any one of the following address fields: Address 1, City, State, Zip Code?*

If you answered "Yes" to the above, you must check this box, affirming that the complete address is not available by any means.

If you answered "No" to the above, ensure that you have entered accurate data into all of the address fields and proceed to the Alias and final Attestation sections

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Alias Information**

Attestation

Under penalty of perjury, the person submitting this data declares that the following is true and correct:

That the information provided on the report page is true and correct. I am submitting this information as required by Section 7.09 of the Mental Hygiene Law.

The individual who is the subject of this report has been, or currently is, a patient, involuntarily admitted to our hospital for mental health treatment.

The sole purpose of the disclosure of this information is to disqualify this individual from possessing a firearm pursuant to 18 USC 922(4)(d).

I understand that providing the patients address and SSN is important and omissions should only be for persons where this information is not known and cannot be reasonably obtained.

Affirm All of the Above*

**Required Fields. ** Repeatable Sections.*

Form Rules:

[1] **Alias Last Name IS REQUIRED IF EXISTS Alias First Name**

[2] **Alias First Name IS REQUIRED IF EXISTS Alias Last Name**

[3] **Social Security Number (no dashes or spaces) IS IN A FORMAT OF SSN(111223333)**